NC Medicaid and NC Health Choice
Pharmacy Prior Approval Request for
Xenazine and tetrabenazine

Beneficiary Information

1. Beneficiary Last Name:_____ 2. First Name: _____
3. Beneficiary ID #:_____ 4. Beneficiary Date of Birth:_____ 5. Beneficiary Gender: _____

Prescriber Information

7. Prescribing Provider NPI #: _____
8. Requester Contact Information
   Name:_____ Phone #:_____ Ext. _____

Drug Information

9. Drug Name: _____ 10. Strength:_____ 11. Quantity Per 30 Days: _____
12. Length of Therapy

Initial Request (days):	30	60	90	120	180	
Continuation Request (days):	30	60	90	120	180	365

Clinical Information

Initial Request

1. Does the beneficiary have a diagnosis of Huntington's Disease and is experiencing signs and symptoms of chorea? ☐ Yes ☐ No
2. Is the beneficiary 18 years old or older? ☐ Yes ☐ No
3. Is the beneficiary receiving dual therapy with other vesicular monoamine transporter 2 (VMAT2) inhibitors? ☐ Yes ☐ No
4. Is the beneficiary concurrently using a monoamine oxidase inhibitor (MAOI) or reserpine? ☐ Yes ☐ No
5. Does the beneficiary have a history of depression or suicidal ideation? ☐ Yes ☐ No
   5a. If yes, is the beneficiary being treated and/or stable? ☐ Yes ☐ No

Continuation Request (must also answer questions 1-5a above)

1. Has the beneficiary met all the above criteria? ☐ Yes ☐ No
2. Has the provider submitted documentation with this request that indicates the beneficiary has had an improvement in their symptoms from baseline? ☐ Yes ☐ No

Signature of Prescriber: _____ Date: _____

**Prescriber Signature mandatory*

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Fax this form to NCTracks at (855) 710-1969

Pharmacy PA Call Center: (866) 246-8505